☐ **Head Office**	☐ **Durban**	☐ **Port Elizabeth**	☐ **Cape Town**
P O Box 78756 Sandton, 2146 113 Katherine Street, Sandown Tel: (011) 520-0000 Fax: (011) 520-0001	P O Box 2183, Durban, 4000 4th Floor, Victoria Maine, 71 Victoria Embankment, Durban, 4001 Tel: (031) 304-0501 Fax: (031) 304-2418	P O Box 27135, Greenacres, Port Elizabeth, 6057 70 - 2nd Avenue, Newton Park, Port Elizabeth, 6045 Tel: (041) 391-5200 Fax: (041) 391-5230	P O Box 1680, Cape Town 5th Floor, South Court Old Town Square , 50 Buitenkant Str. Cape Town 8001 Tel: (021) 464-9100 Fax: (021) 462-4740

Application for Disability Benefit
CLAIMANT'S STATEMENT

FORM 2

Name of Fund:
Employer's Name:

1. PARTICULARS OF CLAIMANT

Surname:	First Name:
Date of Birth:	ID Number:
Residential Address:	Postal Address:
Postal Code:	Postal Code:
Income Tax Office:	Income Tax No.:

2. DETAILS OF OCCUPATION

2.1 Have you been able to perform any part of your occupation since you first became disabled? If so please give datails

____

____

2.2 What was the date you were last actively at work? ____________________

2.3 How long were you in your job before being disabled? ____________________

2.4 Please give a complete and accurate description of the exact duties and nature of your full-time occupation:

____

____

____

____

2.5 Please indicate the percentage of time spent in engaging in:

Manual duties ________ %

Supervisory duties ________ %

Travelling in a motor vehicle ________ %

2.6 Please state details, with dates, of all occupations followed by you during the past 5 years.

Occupation	From	To

3. EDUCATION DETAILS

3.1 Please give details of your education, formal training and any other courses attended.

Dates		University, College or Institution	Grade or Standard Attained
From	To		

3.2 Which other occupations do you consider yourself capable of performing by reason of your training, education, experience and competence? ______________________

____

3.3 When do you expect to be able to resume your work?

Part-time and to what extent? ______________________

Full-time? ______________________

3.4 Are you currently engaged or likely to become engaged in any occupation? YES/NO

If "YES" , please give details of this occupation:

(a) Date of Commencement ______________________

(b) Full-time YES/NO ______________________

(c) Earnings per month R ______________________

4. DETAILS OF DISABLEMENT

3.2 What was the cause of the disability? ______________________________

____

4.2 What was the extend of your injury/illness? ______________________________

____

4.3 How has your disability affected you in performing your normal duties? ______________________________

____

4.4 Please give the names of all doctors, specialists and hospitals you have attended in connection with your disability. Please state patient/hospital numbers where applicable.

Dates		Hospital / Doctor	Address and Telephone No.	Patient Number
From	To			

4.5 Please give the name, address and telephone number of your usual family doctor ______________________________

____

____

4.6 Since what date has he been your family doctor? ______________________________

4.7 When was your last consultation? ______________________________

4.8 Have you, in the last 10 years, suffered from any serious disease, illness or disablement? YES/NO

If "YES" , please state the nature of the disease, illness or disablement ______________________________

____

____

____

4.9 Please give details of doctors and hospitals attended ______________________________

____

____

____

4.10 Please complete if your disability arose from an accident or other violent means:

Date of accident:
What type of accident / incident occurred?
Police station where reported:
Police case number:

OR

Please complete if your disability arose from illness:

List of Complaints	Date Symptoms First Noticed	

5. OTHER COMPENSATION

Please list those sources of compensation which you may receive as a result of your disability.

	Workman's Compensation	Pension or Provident Fund	Disability Policies Arranged by Employer	Disability Policies Arranged by Yourself
Estimated Amount of Benefit				
How is Benefit Payable e.g. Monthly, Lump Sum				
Date Benefit is or Becomes Payable				
For how long is the benefit Payable?				

DECLARATION

I hereby authorise any medical practitioner, hospital, employer or other person to furnish the Insurance Company or its representatives with any information relating to my illness or injury. I hereby declare and warrant that the answers given by me in this claim form are, in every respect, true and correct, and that no material information has been withheld nor relevant circumstances omitted.

DATE ____________________ SIGNATURE ____________________

WITNESS ____________________

NBC Holdings (Proprietary) Limited
Reg No: 1997/012056/07